Medtronic

Nasal and Sinus Procedures

Commonly Billed Codes

Effective January 1, 2024

Nasal and Sinus Procedures

Commonly Billed Codes

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For questions please contact us at ent.us.reimbursement@medtronic.com

ICD-10-CM[1] diagnosis codes

Diagnosis codes are used by both physicians and hospitals to document the indication for the procedure. Because symptoms codes are generally not acceptable as the principal diagnosis, the principal diagnosis is coded to the underlying condition as shown.

Acute recurrent sinusitis	J01.01	Acute recurrent maxillary sinusitis
	J01.11	Acute recurrent frontal sinusitis
	J01.21	Acute recurrent ethmoidal sinusitis
	J01.31	Acute recurrent sphenoidal sinusitis
	J01.41	Acute recurrent pansinusitis
	J01.81	Other acute recurrent sinusitis
	J01.91	Acute recurrent sinusitis, unspecified
Chronic sinusitis	J32.0	Chronic maxillary sinusitis
	J32.1	Chronic frontal sinusitis
	J32.2	Chronic ethmoidal sinusitis
	J32.3	Chronic sphenoidal sinusitis
	J32.4	Chronic pansinusitis
	J32.8	Other chronic sinusitis
	J32.9	Chronic sinusitis, unspecified
Nasal and septal disorders	J33.0	Polyp of nasal cavity
	J33.1	Polypoid sinus degeneration
	J33.8	Other polyp of sinus (accessory, ethmoidal, maxillary, sphenoidal)
	J33.9	Nasal polyp, unspecified
	J34.1	Cyst and mucocele of nose and nasal sinus
	J34.2	Deviated nasal septum (acquired)
	J34.3	Hypertrophy of nasal turbinates
	J34.89	Other specified disorder of nose and nasal sinuses
	J34.9	Unspecified disorder of nose and nasal sinuses
Eustachian tube dysfunction	H69.8	Other specified disorders of eustachian tube
	H69.9	Unspecified eustachian tube disorder

HCPCS II device codes[2]

These codes are used by the entity that purchased and supplied the medical device, DME, drug, or supply to the patient. Medicare provides C-codes for hospital use in billing Medicare for medical devices in the outpatient setting. Although other payers may also accept C-codes, regular HCPCS II device codes are generally used for billing non-Medicare payers. ASCs, however, usually should not assign or report HCPCS II device codes for devices on claims sent to Medicare. Medicare generally does not make a separate payment for devices in the ASC. Instead, payment is "packaged" into the payment for the ASC procedure. ASCs are specifically instructed not to bill HCPCS II device codes to Medicare for devices that are packaged.[3]

Device or Product	HCPCS	Description / Comment
ENT Slide-On™ Endosheath™ System[4]	A4270	Disposable endoscope sheath, each
NuVent™ EM Sinus Dilation System[4]	C1726	Catheter, balloon dilation, non-vascular
NuVent™ Eustachian Tube Dilation Balloon	C1726	Catheter, balloon dilation, non-vascular
Novapak™ Nasal Sinus Packing and Stent[4]	C1763	Connective tissue, non-human (includes synthetic)
MeroGel™ Bioresorbable Nasal Packing Products[4]	C1763	Connective tissue, non-human (includes synthetic)
MeroPack™ Bioresorbable Nasal Dressing and Sinus Stent[4]	C1763	Connective tissue, non-human (includes synthetic)
Chitogel™ Endoscopic Sinus Surgery Kit[4]	C1763	Connective tissue, non-human (includes synthetic)
HydroCleanse™ Sinus Wash Delivery System[5] & Hydrodebrider™ Endoscopic Sinus Irrigation System[4]	N/A[5]	Consider reporting associated charges under general revenue code 270 for medical-surgical supplies.
Nasal Septal Button	N/A[5]	Consider reporting associated charges under general revenue code 270 for medical-surgical supplies.
Powered Surgical Equipment: Console, Microdebrider, Burs & Blades	N/A[5]	Consider reporting associated charges under general revenue code 270 for medical-surgical supplies.
ENT Navigation System: Instruments & Accessories	N/A[5]	Consider reporting associated charges under general revenue code 270 for medical-surgical supplies.

1. Centers for Disease Control and Prevention, National Center for Health Statistics. International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). https://www.cdc.gov/nchs/icd/Comprehensive-Listing-of-ICD-10-CMFiles. htm . Accessed November 16, 2023.
2. Healthcare Common Procedure Coding System (HCPCS) Level II codes, including device C-codes, are maintained by the Centers for Medicare and Medicaid Services. https://www.cms.gov/medicare/coding/hcpcsreleasecodesets/hcpcsquarterly- update . Accessed November 16, 2023.
3. ASCs should report all charges incurred. However, only charges for non-packaged items should be billed as separate line items. Because of a Medicare requirement to pay the lesser of the ASC rate or the line-item charge, breaking these packaged charges out onto their own lines can result in incorrect payment to the ASC. Centers for Medicare and Medicaid Services. Medicare Claims Processing Manual, Chapter 14—Ambulatory Surgical Centers, Section 40. http://www.cms.gov/ Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c14.pdf. Accessed November 16, 2023.
4. Slide-On™ , EndoSheath™, NuVent™, MeroGel™ , MeroPack™ , Novapak™, HydroCleanse™, Hydrodebrider™ are trademarks of Medtronic, Inc. Chitogel™ is distributed by Medtronic, Inc.
5. N/A indicates that CMS and other payers do not have a need for these items to be individually identified, although the associated charges must still be reported. When hospitals use a device or supply that does not have a HCPCS II code, they should report the charges in the general revenue code for the item, typically revenue code 270 for Medical-Surgical Supplies.

Physician Coding and Payment – Effective January 1, 2024

CPT™* Procedure Codes

Physicians use CPT codes for all services. Under Medicare's Resource-Based Relative Value Scale (RBRVS) methodology for physician payment, each CPT code is assigned a point value, known as the relative value unit (RVU), which is then converted to a flat payment amount.

Procedure	CPT code and description[1]	Surgical global[2]	Medicare RVUs[3]		Medicare national average[4]	
			For physician services provided in:[5]			
			Physician office[6]	Facility	Physician office[6]	Facility
Computerized tomography[7]	**70486** Computed tomography, maxillofacial area, without contrast material (CT Sinus)	N/A	3.94	N/A	$129	N/A
Surgical navigation[8]	**61782** Stereotactic computer-assisted (navigational)procedure, cranial, extradural	N/A	N/A	5.13	$168	$168
Inferior turbinate resection/ ablation, rhinoplasty, septoplasty, & sinus lavage[9]	**30110** Excision nasal polyp (s), simple	010	7.52	4.03	$246	$132
	30115 Excision nasal polyp (s), extensive	090	N/A	14.11	$462	$462
	30140 Submucous resection, inferior turbinate, partial or complete, any method[10]	000	8.91	5.33	$292	$175
	30220 Insertion, nasal septal prosthesis (button)	010	9.16	3.89	$300	$127
	30420 Rhinoplasty, primary; including major septal repair	090	N/A	43.81	$1,435	$1,435
	30465 Repair of nasal vestibular stenosis (e.g. spreader grafting, lateral nasal wall reconstruction)[11,12]	090	N/A	31.00	$1,015	$1,015
	30520 Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft[12]	090	N/A	20.43	$669	$669
	30620 Septal or other intranasal dermatoplasty	090	N/A	20.42	$669	$669
	30630 Repair nasal septal defect	090	N/A	20.24	$663	$663
	30801 Cautery and/or ablation, mucosa of inferior turbinates, unilateral or bilateral, any method; superficial	010	6.59	4.60	$216	$151
	30802 Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (e.g. electrocautery, radiofrequency ablation, or tissue volume reduction), intramural (i.e. submucosal)[10]	010	8.38	6.12	$274	$200
	30930 Fracture nasal inferior turbinate(s), therapeutic[10]	010	N/A	3.59	$118	$118
	31000 Lavage by cannulation; maxillary sinus (antrum puncture or natural ostium)	010	5.61	3.35	$184	$110
	31002 Lavage by cannulation; sphenoid sinus (antrum puncture or natural ostium)	010	N/A	5.71	$187	$187

Physician Coding and Payment – continued

Procedure	CPT code and description[1]	Surgical global[2]	Medicare RVUs[3]		Medicare national average[4]	
			For physician services provided in:[5]			
			Physician office[6]	Facility	Physician office[6]	Facility
Nasal/Sinus endoscopy [9,13]	**31231** Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)	000	5.63	1.93	$184	$63
	31233 Diagnostic endoscopy of nose and maxillary sinus via inferior meatuspuncture	000	8.25	4.06	$270	$133
	31237 Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridements (separate procedure)	000	7.74	4.79	$253	$157
	31238 Surgical endoscopy of nose with control of nasal hemorrhage	000	7.54	5.01	$247	$164
	31240 Nasal/sinus endoscopy, surgical; with concha bullosa resection	000	N/A	4.76	$156	$156
	31241 Nasal/sinus endoscopy, surgical; with ligation of sphenopalatine artery	000	N/A	13.27	$435	$435
	31253 Nasal/sinus endoscopy, surgical with ethmoidectomy, total (anterior and posterior) including frontal sinus exploration; with or without removal of tissue from frontal sinus	000	N/A	14.88	$487	$487
	31254 Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)	000	13.13	7.25	$430	$237
	31255 Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior)	000	N/A	9.63	$315	$315
	31256 Nasal/sinus endoscopy, surgical, with maxillary antrostomy	000	N/A	5.37	$176	$176
	31257 Nasal/sinus endoscopy, surgical with ethmoidectomy, total (anterior and posterior) including sphenoidotomy	000	N/A	13.28	$435	$435
	31259 Nasal/sinus endoscopy, surgical with ethmoidectomy, total (anterior and posterior) including sphenoidotomy, with removal of tissue from sphenoid sinus	000	N/A	14.03	$459	$459
	31267 Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus	000	N/A	7.92	$259	$259
	31276 Nasal/sinus endoscopy, surgical with frontal sinus exploration; with or without removal of tissue from frontal sinus	000	N/A	11.27	$369	$369

Physician Coding and Payment – continued

Procedure	CPT code and description[1]	Surgical global[2]	Medicare RVUs[3]		Medicare national average[4]	
			For physician services provided in:[5]			
			Physician office[6]	Facility	Physician office[6]	Facility
Nasal/Sinus endoscopy [9,13]	**31287** Nasal/sinus endoscopy, surgical, with sphenoidotomy	000	N/A	6.00	$196	$196
	31288 Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus	000	N/A	6.98	$229	$229
	31295 Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (e.g. balloon dilation), transnasal or via canine fossa	000	49.29	4.71	$1,614	$154
	31296 Nasal/sinus endoscopy, surgical: with dilation of frontal sinus ostium (e.g. balloon dilation)	000	50.05	5.35	$1,639	$175
	31297 Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (e.g. balloon dilation)	000	48.86	4.30	$1,600	$141
	31298 Nasal/sinus endoscopy, surgical; with dilation of frontal and sphenoid sinus ostium (e.g. balloon dilation)	000	92.68	7.63	$3,035	$250
	NOTE: CPT codes 31295, 31296, 31297 and 31298 apply to cases in which a balloon catheter is the only instrument or tool used and no tissue is removed. Do not report 31295, 31296, 31297, or 31298 with endoscopic sinus surgery codes when performed on same sinus.[14]					
Balloon Dilation of Eustachian Tube (BDET)	**69705** Nasopharyngoscopy, surgical, with dilation of the eustachian tube (i.e balloon dilation); unilateral	000	80.55	5.19	$2,638	$170
	69706 Nasopharyngoscopy, surgical, with dilation of the eustachian tube (i.e balloon dilation); bilateral	000	83.22	7.25	$2,725	$237
	NOTE: Based on Medicare NCCI Procedure to Procedure edits, CPT codes 30801, 30802 or 31231 should not be reported with CPT codes 69705 and 69706. For distinct and separate services, the use of an appropriate modifier may be applicable. Please consult with your local Medicare Administrative Contractor accordingly.[15]					

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2. Surgical procedures are subject to a "global period." The global period defines other physician services that are generally considered part of the surgery package. The services are not separately coded, billed, or paid when rendered by the physician who performed the surgery. These services include: preoperative visits the day before or the day of the surgery, postoperative visits related to recovery from the surgery for 10 days or 90 days depending on the specific procedure, treatment of complications unless they require a return visit to the operating room, and minor postoperative services such as dressing changes and suture removal. Medicare Claims Processing Manual . Chapter 12, Section 40.1. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c12.pdf. Accessed December 4, 2023.
3. Centers for Medicare & Medicaid Services Revisions to Payment Policies under the Medicare Physician Fee Schedule Quality Payment Program and Other Revisions to Part B for CY 2024; CMS-1784-F. https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeesched/pfs-federal-regulation-notices/cms-1784-f. Accessed December 4, 2023. The total RVU as shown here is the sum of three components: physician work RVU, practice expense RVU, and malpractice RVU.

Physician Coding and Payment – continued

4. Medicare national average payment is determined by multiplying the sum of the three RVUs by the conversion factor. The conversion factor for CY 2024 is $32.7442, a decrease of 3.4% from the CY 2023 conversion factor. Calendar Year (CY) 2024 Medicare Physician Fee Schedule Final Rule. https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule. Accessed December 6, 2023.
5. The RVUs shown are for the physician's services and payment is made to the physician. However, there are different RVUs and payments depending on the setting in which the physician rendered the service. "Facility" includes physician services rendered in hospitals, ASCs, and SNFs. Physician RVUs and payments are generally lower in the "Facility" setting because the facility is incurring the cost of some of the supplies and other materials. Physician RVUs and payments are generally higher in the "Physician Office" setting because the physician incurs all costs there.
6. "N/A" shown in Physician Office setting indicates that Medicare has not developed RVUs in the office setting because the service is typically performed in a facility (e.g.in a hospital). However, if the local contractor determines that it will cover the service in the office, then it is paid using the facility RVUs at the facility rate.
7. Allowable rate includes both the technical and professional components. When billing for professional service only, a 52 modifier would be added and allowable rate would be reduced accordingly.
8. As medically necessary, the use of a stereotactic guidance system may be reported in addition to the appropriate codes for the primary ENT procedure. Documentation should explain both the medical necessity and pre-planning activities. CPT code 61782 is an "add-on" code and must be reported in addition to the primary procedure.
9. Modifier -50 is used to report bilateral procedures that are performed at the same operative session as a single line item. Do not use modifiers RT and LT when modifier -50 applies. Do not submit two line items to report a bilateral procedure using modifier -50 . If a procedure is identified by the terminology as bilateral (or "unilateral or bilateral"), as in codes 30801 and 30802, physicians do not report the procedure with modifier "-50." Medicare Claims Processing Manual, Chapter 12–Physicians and Nonphysicians Practitioners, Section 40.7. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c12.pdf. Accessed December 6, 2023.
10. Coding for turbinoplasty procedures is based on whether bone was removed during procedure. Soft tissue reduction of turbinates, without removal of bone, is reported with code 30802. If bone is removed, it is reported with 30140. Turbinoplasty and outfracture are sometimes performed together. According to NCCI edits and/or CPT descriptions, CPT code 30930 should not be billed with 30140. If CPT codes code 30802 and 30930 are reported together, only one code is paid unless procedures are performed independently on opposite sides.
11. CPT 30465 is used to report a bilateral procedure. For unilateral procedure, use modifier - 52.
12. You may also report a separate code when you harvest graft material through a separate incision (e.g. 20912- Cartilage graft; nasal septum). However, if a septoplasty (CPT 30520) is performed and reported during the same operative session, then you may not separately report graft harvest.
13. Special rules for multiple endoscopic procedures apply when nasal/sinus endoscopy procedures are billed together for the same patient on the same day. Multiple endoscopic payment rules apply to a code family before ranking the family with other procedures performed on the same day. When a nasal/sinus endoscopy procedure is reported together with its base procedure, CPT 31231, then, payment for the base procedure is included in the payment for the other nasal/sinus endoscopy procedure. For additional information about the payment adjustment under the special rule for multiple endoscopic services, please reference CY 1992 PFS final rule where this policy was established (56 FR 59515) and to Pub. 100-04, Medicare Claims Processing Manual, Chapter 23. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf. Updated June 6, 2023. Accessed December 6, 2023.
14. CPT Assistant, January 2010/Volume 20, Issue 1.
15. Medicare National Correct Coding Initiative (NCCI) Procedure-To-Procedure (PTP) Code Pair Edits . https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-procedure-procedure-ptp-edits. Accessed December 8, 2023.

Hospital Outpatient Coding and Payment – Effective January 1, 2024

CPT™* Procedure Codes

Hospitals use CPT codes for outpatient services. Under Medicare's APC methodology for hospital outpatient payment, each CPT code is assigned to an APC. Each APC has a relative weight that is then converted to a flat payment amount. Multiple APCs can sometimes be assigned for each encounter, depending on the number of procedures coded and whether any of the procedure codes map to a Comprehensive APC (C-APC). A CPT procedure code assigned to C-APC is considered a primary service, and all other procedures and services coded on the bill are considered adjunctive to delivery of the primary service. This results in a single APC payment and a single beneficiary copayment for the entire outpatient encounter, based solely on the primary service. Separate payment is not made for any of the other adjunctive services. Instead, the payment level for the C-APC is calculated to include the costs of the other adjunctive services, which are packaged into the payment for the primary service. When more than one primary service is coded for the same outpatient encounter, the codes are ranked according to a fixed hierarchy. The C-APC is then assigned according to the highest ranked code. In some special circumstances, the combination of two primary services leads to a "complexity adjustment" in which the entire encounter is re-mapped to another higher-level APC. As shown on the tables below, the procedures that are subject to C-APCs are identified by status indicator J1.

Procedure	CPT code and description[1]	APC[2]	APC title[2]	SI[2,3]	Relative weight[2]	Medicare national average[2,4]
Surgical navigation	**61782** Stereotactic computer-assisted (navigational) procedure, cranial, extradural	N/A	N/A	N	N/A	N/A
Inferior turbinate resection/ ablation, rhinoplasty, septoplasty, & sinus lavage[5]	**30115** Excision nasal polyp (s), extensive	5164	Level 4 ENT procedures	J1	35.1059	$3,068
	30140 Submucous resection, inferior turbinate, partial or complete, any method[6]	5164	Level 4 ENT procedures	J1	35.1059	$3,068
	30420 Rhinoplasty, primary; including major septal repair	5165	Level 5 ENT procedures	J1	63.8542	$5,580
	30465 Repair of nasal vestibular stenosis (e.g. spreader grafting, lateral nasal wall reconstruction)[7,8]	5165	Level 5 ENT procedures	J1	63.8542	$5,580
	30520 Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft[8]	5164	Level 4 ENT procedures	J1	35.1059	$3,068
	30620 Septal or other intranasal dermatoplasty	5165	Level 5 ENT procedures	J1	63.8542	$5,580
	30630 Repair nasal septal defect	5164	Level 4 ENT procedures	J1	35.1059	$3,068
	30801 Cautery and/or ablation, mucosa of inferior turbinates, unilateral or bilateral, any method; superficial	5163	Level 3 ENT procedures	J1	16.6287	$1,453

Hospital Outpatient Coding and Payment – continued

CPT™* Procedure Codes

Procedure	CPT code and description[1]	APC[2]	APC title[2]	SI[2,3]	Relative weight[2]	Medicare national average[2,4]
Inferior turbinate resection/ ablation, rhinoplasty, septoplasty, & sinus lavage[5]	**30802** Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (e.g. electrocautery, radiofrequency ablation, or tissue volume reduction), intramural (i.e. submucosal)[6]	5163	Level 3 ENT procedures	J1	16.6287	$1,453
	30930 Fracture nasal inferior turbinate(s), therapeutic[6]	5164	Level 4 ENT procedures	J1	35.1059	$3,068
	31000 Lavage by cannulation; maxillary sinus (antrum puncture or natural ostium)	5161	Level 1 ENT procedures	T	2.6634	$233
	31002 Lavage by cannulation; sphenoid sinus (antrum puncture or natural ostium)	5163	Level 3 ENT procedures	J1	16.6287	$1,453
Nasal and sinus endoscopy[5]	**31231** Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)	5151	Level 1 airway endoscopy	T	2.1598	$189
	31233 Diagnostic endoscopy of nose and maxillary sinus via inferior meatuspuncture	5152	Level 2 airway endoscopy	T	4.4523	$389
	31237 Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridements (separate procedure)	5153	Level 3 airway endoscopy	J1	18.5066	$1,617
	31238 Surgical endoscopy of nose with control of nasal hemorrhage	5153	Level 3 airway endoscopy	J1	18.5066	$1,617
	31240 Nasal/sinus endoscopy, surgical; with concha bullosa resection	5153	Level 3 airway endoscopy	J1	18.5066	$1,617
	31241 Nasal/sinus endoscopy, surgical; with ligation of sphenopalatine artery	5153	Level 3 airway endoscopy	J1	18.5066	$1,617
	31253 Nasal/sinus endoscopy, surgical with ethmoidectomy, total (anterior and posterior) including frontal sinus exploration; with or without removal of tissue from frontal sinus	5155	Level 5 airway endoscopy	J1	74.6285	$6,521
	31254 Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)	5155	Level 5 airway endoscopy	J1	74.6285	$6,521

Hospital Outpatient Coding and Payment – continued

CPT™* Procedure Codes

Procedure	CPT code and description[1]	APC[2]	APC title[2]	SI[2,3]	Relative weight[2]	Medicare national average[2,4]
Nasal and sinus endoscopy[5]	**31255** Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior)	5155	Level 5 airway endoscopy	J1	74.6285	$6,521
	31256 Nasal/sinus endoscopy, surgical, with maxillary antrostomy	5154	Level 4 airway endoscopy	J1	40.8328	$3,568
	31257 Nasal/sinus endoscopy, surgical with ethmoidectomy, total (anterior and posterior) including sphenoidotomy	5155	Level 5 airway endoscopy	J1	74.6285	$6,521
	31259 Nasal/sinus endoscopy, surgical with ethmoidectomy, total (anterior and posterior) including sphenoidotomy, with removal of tissue from sphenoid sinus	5155	Level 5 airway endoscopy	J1	74.6285	$6,521
	31267 Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus	5155	Level 5 airway endoscopy	J1	74.6285	$6,521
	31276 Nasal/sinus endoscopy, surgical with frontal sinus exploration; with or without removal of tissue from frontal sinus	5155	Level 5 airway endoscopy	J1	74.6285	$6,521
	31287 Nasal/sinus endoscopy, surgical, with sphenoidotomy	5155	Level 5 airway endoscopy	J1	74.6285	$6,521
	31288 Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus	5155	Level 5 airway endoscopy	J1	74.6285	$6,521
	31295 Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (e.g. balloon dilation), transnasal or via canine fossa	5155	Level 5 airway endoscopy	J1	74.6285	$6,521
	31296 Nasal/sinus endoscopy, surgical: with dilation of frontal sinus ostium (e.g. balloon dilation)	5155	Level 5 airway endoscopy	J1	74.6285	$6,521

Hospital Outpatient Coding and Payment – continued

CPT™* Procedure Codes

Procedure	CPT code and description[1]	APC[2]	APC title[2]	SI[2,3]	Relative weight[2]	Medicare national average[2,4]
Nasal and sinus endoscopy[5]	**31297** Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (e.g. balloon dilation)	5155	Level 5 airway endoscopy	J1	74.6285	$6,521
	31298 Nasal/sinus endoscopy, surgical; with dilation of frontal and sphenoid sinus ostium (e.g. balloon dilation)	5155	Level 5 airway endoscopy	J1	74.6285	$6,521
	NOTE: CPT codes 31295, 31296,31297 and 31298 apply to cases in which a balloon catheter is the only instrument or tool used and no tissue is removed. Do not report 31295, 31296, 31297 or 31298 with endoscopic sinus surgery codes when performed on same sinus.9					
Balloon Dilation of Eustachian Tube (BDET)	**69705** Nasopharyngoscopy, surgical, with dilation of the eustachian tube (i.e balloon dilation); unilateral	5165	Level 5 ENT procedures	J1	63.8542	$5,580
	69706 Nasopharyngoscopy, surgical, with dilation of the eustachian tube (i.e balloon dilation); bilateral	5165	Level 5 ENT procedures	J1	63.8542	$5,580
	NOTE: Based on Medicare NCCI Procedure to Procedure edits, CPT codes 30801, 30802 or 31231 should not be reported with CPT codes 69705 and 69706. For distinct and separate services, the use of an appropriate modifier may be applicable. Please consult with your local Medicare Administrative Contractor accordingly.[15]					

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2. Centers for Medicare & Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals: Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral; New Service Category for Hospital Outpatient Department Prior Authorization Process; Overall Hospital Quality Star Rating; COVID-19 ; https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and/cms-1786-fc . Accessed December 14, 2023.
3. Status Indicator (SI) shows how a code is handled for payment purposes: J1 = paid under a comprehensive APC, single payment based on primary service without separate payment for other adjunctive services; N = packaged service, no separate payment; T = Significant procedure subject to multiple procedure discounting.
4. Medicare national average payment rate is determined by multiplying the APC weight by the conversion factor. The final conversion factor for 2024 is $87.382 as published in CMS-1786-fc. The conversion factor of 87.382 assumes that hospitals meet reporting requirements of the Hospital Outpatient Quality Data Reporting Program. https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and/cms-1786-fc. Accessed December 14, 2023.
5. Modifier -50 is used to report bilateral procedures that are performed at the same operative session as a single line item. Do not use modifiers RT and LT when modifier -50 applies. Do not submit two line items to report a bilateral procedure using modifier -50 . Medicare Claims Processing Manual, Chapter 4—Part B Hospital, sections 20.6 and 20.6.2. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf . Accessed December 14, 2023.
6. Coding for turbinoplasty procedures is based on whether bone was removed during procedure. Soft tissue reduction of turbinates, without removal of bone, is reported with code 30802. If bone is removed, it is reported with 30140. Turbinoplasty and outfracture are sometimes performed together. According to NCCI edits and/or CPT descriptions, CPT code 30930 should not be billed with 30140. If CPT codes code 30802 and 30930 are reported together, only one code is paid unless procedures are performed independently on opposite sides.
7. CPT 30465 is used to report a bilateral procedure. For unilateral procedure, use modifier - 52.
8. You may also report a separate code when you harvest graft material through a separate incision (e.g. 20912- Cartilage graft; nasal septum). However, if a septoplasty (CPT 30520) is performed and reported during the same operative session, then you may not separately report graft harvest.
9. CPT Assistant, January 2010/Volume 20, Issue 1.
10. Medicare National Correct Coding Initiative (NCCI) Procedure-To-Procedure (PTP) Code Pair Edits . https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-procedure-procedure-ptp-edits. Accessed December 14, 2023.

Nasal and Sinus Procedures
Commonly Billed Codes

ASC Coding and Payment – Effective January 1, 2024

CPT™* Procedure Codes

ASCs use CPT codes for their services. Medicare payment for procedures performed in an ambulatory surgery center is based on Medicare's ambulatory patient classification (APC) methodology for hospital outpatient payment. However, Comprehensive APCs (C-APCs) are used only for hospital outpatient services and are not applied to procedures performed in ASCs. Each CPT code designated as a covered procedure in an ASC is assigned a comparable weight as under the hospital outpatient APC system. This is then converted to a flat payment amount using a conversion factor unique to ASCs. Multiple procedures can be paid for each claim. Certain ancillary services, such as imaging, are also covered when they are integral to covered surgical procedures, although they may not be separately payable. In general, there is no separate payment for devices; their payment is packaged into the payment for the procedure.

Procedure	CPT code and description[1]	Payment indicator[2,3]	Multiple procedure discounting[5]	Relative weight[2,4]	Medicare national average[2,4]
Surgical navigation	**61782** Stereotactic computer-assisted (navigational) procedure, cranial, extradural	N1	N	N/A	N/A
Inferior turbinate resection/ ablation, rhinoplasty, septoplasty, & sinus lavage[5]	**30115** Excision nasal polyp (s), extensive	A2	Y	24.6457	$1,319
	30140 Submucous resection, inferior turbinate, partial or complete, any method[6]	A2	Y	24.6457	$1,319
	30220 Insertion, nasal septal prosthesis (button)	A2	Y	12.4609	$667
	30420 Rhinoplasty, primary; including major septal repair	A2	Y	51.5906	$2,761
	30465 Repair of nasal vestibular stenosis (e.g. spreader grafting, lateral nasal wall reconstruction)[7,8]	A2	Y	51.5906	$2,761
	30520 Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft[8]	A2	Y	24.6457	$1,319
	30620 Septal or other intranasal dermatoplasty	A2	Y	51.5906	$2,761
	30630 Repair nasal septal defect	A2	Y	24.6457	$1,319
	30801 Cautery and/or ablation, mucosa of inferior turbinates, unilateral or bilateral, any method; superficial	A2	Y	12.4609	$667
	30802 Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (e.g. electrocautery, radiofrequency ablation, or tissue volume reduction), intramural (i.e. submucosal)[8]	A2	Y	12.4609	$667
	30930 Fracture nasal inferior turbinate(s), therapeutic[8]	A2	Y	24.6457	$1,319
	31000 Lavage by cannulation; maxillary sinus (antrum puncture or natural ostium)	P2	Y	2.3678	$127
	31002 Lavage by cannulation; sphenoid sinus (antrum puncture or natural ostium)	R2	Y	12.4609	$667

ASC Coding and Payment – continued

CPT™* Procedure Codes

Procedure	CPT code and description[1]	Payment indicator[2,3]	Multiple procedure discounting[5]	Relative weight[2,4]	Medicare national average[2,4]
Nasal and sinus endoscopy[6,7]	**31231** Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)	P2	Y	1.9201	$103
	31233 Diagnostic endoscopy of nose and maxillary sinus via inferior meatus puncture	A2	Y	3.9581	$212
	31237 Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridements (separate procedure)	A2	Y	14.1483	$757
	31238 Surgical endoscopy of nose with control of nasal hemorrhage	A2	Y	14.1483	$757
	31240 Nasal/sinus endoscopy, surgical; with concha bullosa resection	A2	Y	14.1483	$757
	31253 Nasal/sinus endoscopy, surgical with ethmoidectomy, total (anterior and posterior) including frontal sinus exploration; with or without removal of tissue from frontal sinus	G2	Y	42.9994	$2,301
	31254 Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)	A2	Y	42.9994	$2,301
	31255 Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior)	A2	Y	42.9994	$2,301
	31256 Nasal/sinus endoscopy, surgical, with maxillary antrostomy	A2	Y	29.2749	$1,567
	31257 Nasal/sinus endoscopy, surgical with ethmoidectomy, total (anterior and posterior) including sphenoidotomy	G2	Y	42.9994	$2,301
	31259 Nasal/sinus endoscopy, surgical with ethmoidectomy, total (anterior and posterior) including sphenoidotomy, with removal of tissue from sphenoid sinus	G2	Y	42.9994	$2,301
	31267 Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus	A2	Y	42.9994	$2,301
	31276 Nasal/sinus endoscopy, surgical with frontal sinus exploration; with or without removal of tissue from frontal sinus	A2	Y	42.9994	$2,301
	31287 Nasal/sinus endoscopy, surgical, with sphenoidotomy	A2	Y	42.9994	$2,301
	31288 Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus	A2	Y	42.9994	$2,301

ASC Coding and Payment – continued

CPT™* Procedure Codes

Procedure	CPT code and description[1]	Payment indicator[2,3]	Multiple procedure discounting[5]	Relative weight[2,4]	Medicare national average[2,4]
Nasal and sinus endoscopy[6,7]	**31295** Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (e.g. balloon dilation), transnasal or via canine fossa	J8	Y	54.7268	$2,888
	31296 Nasal/sinus endoscopy, surgical: with dilation of frontal sinus ostium (e.g. balloon dilation)	P3	Y		$1,523
	31297 Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (e.g. balloon dilation)	P3	Y		$1,508
	31298 Nasal/sinus endoscopy, surgical; with dilation of frontal and sphenoid sinus ostium (e.g. balloon dilation)	P2	Y	42.9994	$2,301
	NOTE: CPT codes 31295, 31296 , 31297 and 31298 apply to cases in which a balloon catheter is the only instrument or tool used and no tissue is removed. Do not report 31295, 31296 , 31297 and 31298 with endoscopic sinus surgery codes when performed on same sinus. 11				
Balloon Dilation of Eustachian Tube (BDET)	**69705** Nasopharyngoscopy, surgical, with dilation of the eustachian tube (i.e balloon dilation); unilateral	J8	Y	72.8471	$3,898
	69706 Nasopharyngoscopy, surgical, with dilation of the eustachian tube (i.e balloon dilation); bilateral	J8	Y	71.9189	$3,849
	NOTE: Based on Medicare NCCI Procedure to Procedure edits, CPT codes 30801, 30802 or 31231 should not be reported with CPT codes 69705 and 69706. For distinct and separate services, the use of an appropriate modifier may be applicable. Please consult with your local Medicare Administrative Contractor accordingly.[15]				

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2. Centers for Medicare & Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals: Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral; New Service Category for Hospital Outpatient Department Prior Authorization Process; Overall Hospital Quality Star Rating; COVID-19 ; https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1786-fc. Accessed December 18, 2023.
3. The Payment Indicator shows how a code is handled for payment purposes: A2= Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight. G2 = surgical procedure, non-office-based, payment based on hospital outpatient rate adjusted for ASC. J8 = device-intensive procedure, payment amount adjusted to incorporate device cost. N1= Packaged service/item; no separate payment made. P2= office-based surgical procedure added to ASC list in CY 2008 or later with MPFS non-facility PE RVUs; payment based on OPPS relative payment weight. P3= office-based surgical procedure added to ASC list in CY 2008 or later with MPFS non-facility PE RVUs; payment based on MPFS non-facility PE RVUs. R2= Office-based surgical procedure added to ASC list in CY 2008 or later without MPFS non-facility PE RVUs; payment based on OPPS relative payment weight.
4. Medicare national average payment is determined by multiplying the relative weight by the ASC conversion factor. The 2024 ASC conversion factor is $53.514. The conversion factor of $53.514 assumes the ASC meets quality reporting requirements. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs. https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and/cms-1786-fc. Accessed December 18, 2023. Payment is adjusted by the wage index for each ASC's specific geographic locality, so payment will vary from the stated national average Medicare payment levels displayed. Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the national average payment amount shown.

5. When multiple procedures are coded and billed, payment is usually made at 100% of the rate for the first procedure and 50% of the rate for the second and all subsequent procedures. These procedures are marked "Y." However, procedures marked "N" are not subject to this discounting and are paid at 100% of the rate regardless of whether they are submitted with other procedures.
6. For Medicare billing, ASCs use a CMS-1500 form.
7. Medicare does not recognize the use of bilateral modifier -50 for payment in the ASC and instructs that bilateral procedures should either be reported with the CPT procedure code repeated on two separate lines, or reported on a single line with units of "2". Centers for Medicare and Medicaid Services. Medicare Claims Processing Manual, Chapter 14—Ambulatory Surgery Centers, section 40.5: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c14.pdf. Updated March 24, 2023. Accessed December 18, 2023.
8. Coding for turbinoplasty procedures is based on whether bone was removed during procedure. Soft tissue reduction of turbinates, without removal of bone, is reported with code 30802. If bone is removed, it is reported with 30140. Turbinoplasty and outfracture are sometimes performed together. According to NCCI edits and/or CPT descriptions, CPT code 30930 should not be billed with 30140. If CPT codes code 30802 and 30930 are reported together, only one code is paid unless procedures are performed independently on opposite sides.
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11. CPT Assistant, January 2010/Volume 20, Issue 1
12. Medicare National Correct Coding Initiative (NCCI) Procedure-To-Procedure (PTP) Code Pair Edits . https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-procedure-procedure-ptp-edits. Accessed December 18, 2023.

Medtronic

Medtronic Inc.
6743 Southpoint Drive
Jacksonville, FL 32216
USA
Tel. 1-904-296-9600

For further information, please contact Medtronic ENT at 800.874.5797 and/or consult Medtronic ENT website at www.medtronicent.com.